

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

36 -63-019883
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 139

Primary Registration District No.

Registrar's No.

FILED MAY 20 1963

VS 300
Rev. 4/59

1 0440

2 0440

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4 0

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12 86-2

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Mount City</u>		Length of stay in 1b <u>3 yrs.</u>	c. CITY OR TOWN <u>Mount City</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>Duncan Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Mount City</u>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WESLEY</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (last birthday) <u>90</u>
11a. FATHER'S NAME <u>William Smith</u>		11b. MOTHER'S MAIDEN NAME <u>Catherine Shunkwiler</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		13b. NAME OF HUSBAND OR WIFE <u>Caroline Fuhrman</u>	
14. SOCIAL SECURITY NO. <u>156-277-2000</u>		15. INFORMANT <u>Gregory J. Smith</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in: PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>June 1960</u> to <u>May 16/63</u> and last saw her alive on <u>May 15-1963</u> Death occurred at <u>5:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. Bruce M. Roe</u> (Degree or title) <u>AO</u>		22b. ADDRESS <u>Mount City Mo</u>	22c. DATE SIGNED <u>5/16/63</u>
23a. MANNER OF CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-17-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>	23d. LOCATION (City, town, or county) (State) <u>Mount City Mo.</u>
24. FUNERAL DIRECTOR <u>Samuel H. Crawford</u> ADDRESS <u>Mount City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-16-1963</u>	26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

JUL 16 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James H. Crawford*

Licensed Embalmer No. 4796

P. O. Address Round City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.